WORKSHEET 14.1. *Mind Over Mood* Anxiety Inventory

Circle or mark one number for each item that best describes how much you have experienced each symptom over the past week.

	Not at all	Sometimes	Frequently	Most of the time
1. Feeling nervous	0	1	2	3
2. Worrying	0	1	2	3
3. Trembling, twitching, feeling shaky	0	1	2	3
4. Muscle tension, muscle aches, muscle soreness	0	1	2	3
5. Restlessness	0	1	2	3
6. Tiring easily	0	1	2	3
7. Shortness of breath	0	1	2	3
8. Rapid heartbeat	0	1	2	3
9. Sweating not due to the heat	0	1	2	3
10. Dry mouth	0	1	2	3
11. Dizziness or light-headedness	0	1	2	3
12. Nausea, diarrhea, or stomach problems	0	1	2	3
13. Increase in urge to urinate	0	1	2	3
14. Flushes (hot flashes) or chills	0	1	2	3
15. Trouble swallowing or "lump in throat"	0	1	2	3
16. Feeling keyed up or on edge	0	1	2	3
17. Being quick to startle	0	1	2	3
18. Difficulty concentrating	0	1	2	3
19. Trouble falling or staying asleep	0	1	2	3
20. Irritability	0	1	2	3
21. Avoiding places where I might be anxious	0	1	2	3
22. Thoughts of danger	0	1	2	3
23. Seeing myself as unable to cope	0	1	2	3
24. Thoughts that something terrible will happen	0	1	2	3
			Score (sum of item scores)	**0**